DMHAS CSP/RP Fidelity Scale: Notes for Agencies and Fidelity Reviewers

Fidelity Scale Review Process

There will be five main parts to the fidelity scale review process:

- Entry meeting with CSP/RP program/agency leadership (30mins.)
- Interview with CSP/RP team or a sample of the team. (45mins.)
- Focus group with consumers. Ideally, this would include about 6-10 CSP/RP consumers. (30 mins.)

- Chart reviews (**5**-3 active/2 discharged), including a sample of both CSP and RP charts across different staff on the team. It is expected that at least some of the charts will have documentation of family involvement, inclusion of mutual support groups, and recovery/wellness groups. (1 ¾ hours)

- Exit interview with leadership. This will be an opportunity for the reviewers to ask any remaining questions and give preliminary feedback. (30 mins.)

The reviews will take at least 4 hours. Your reviewers may ask for some materials before the visit to facilitate the process. For example, they **may** request the chart review material (e.g., 2 fully completed yearly FAs, 2 FA updates, Recovery plan, Recovery plan updates, Encounter Notes for 5 individuals).

Items your program should have prepared for the visit:

- Team meeting schedule
- Supervision schedule and log
- Skill-builder toolkit (i.e curricula, lists, resources etc.)
- 5 Charts as described above
- Schedules of skill-building groups, recovery/wellness groups, and mutual support groups
- Family group agendas/attendance log
- Documentation showing percentage of clients with families that are engaged with the team(e.g., attending a tx plan meeting; be added to the recovery plan to assist with a certain goal/objective…to do a certain intervention; regular contact with the CSP/RP staff member etc.)

Notes on some of the fidelity scale items :(Not all items in the fidelity scale are commented on below. Only the items that appear to need clarification and further explanation are included)

Fidelity Scale Item	Notes
#1 Peer Support Position	Need to be AU certified; if not certified by AU, score = 1
#2 CSP/RP Team Availability	These hours should be listed on your agency's CSP/RP Member Handbook and Brochure; CSP/RP team operates at least 10 hrs/day, 5 days/week; available for scheduled evening/weekend appts as needed Teams should ensure that CSP/RP clients are aware of these hours; this is asked about in the consumer focus group; Agencies do not need to staff their clinics for additional hours with secretaries, clinicians and other staff to meet this requirement. CSP/RP staff working the extended hours can be in the community meeting with clients, looking for clients that are missing or not yet engaged, and/or doing paperwork at another location (not home).

Fidelity Scale Item	Notes
#3 <u>Team Meetings</u>	These meetings could be ½ hour in length and are often called "morning meetings". It may be that not all staff can be at all of these meetings, given the extended hours' schedule. These meetings can take place by conference call. These meetings are different than group supervision meetings. The agenda for these routine weekly meetings can include daily update on current client issue, week in review, weekend or emergency client concerns, daily schedules, and case presentations. The agenda is generally around supporting each other and working in concert. To meet fidelity, a CSP/RP team must meet together at least 2 times weekly.
#4 <u>Supervision</u>	Reviewers will ask for a supervision log or other documentation (e.g., agendas) showing evidence of the frequency and content of the individual and group sessions. In order to meet CSP/RP fidelity (score of "4"), each CSP/RP staff member should receive over 2.5 hours of clinical supervision monthly. Clinical Supervision: **Basic Principles**: 1.Clinical supervision focuses on the counselor* and not on the client, 2. It occurs within the relationship between the counselor and the supervisor, 3.It asks the questions, "what does the counselor want/need and how can I, as the supervisor, help", 4. It addresses obstacles and roadblocks that may be hampering the relationship between the counselor and the client, 5.It addresses models, techniques, and implementation of the evidence-based practices endorsed by the agency, 6.It defines and supports ethical practices, 7.It clarifies and supports training initiatives, and 8. It builds on the strength of the counselor. ***** Counselor is broadly defined as a staff member who works directly with clients in a helping or support role. He/she can be a licensed mental health professional, a recovery specialist, case manager, residential counselor, etc.
Domain 2 – Administrative Data Items	We will use FY15, Quarter 2 (October-December 2014) data to rate the administrative data items in this round of fidelity reviews.
#11 and 12 <u>Functional Assessment</u>	The charts reviewed must show evidence of on **admission** full FA. The frequency should be upon admission (within 90 days) (or more often based on changing needs and/or establishment of a new rehab goal). If using the DLA-20, please include the Self Advocacy/Rights domain. In terms of the functional assessment (FA) update, there is flexibility in how this can be accomplished. There is an optional DMHAS FA Update template on the DMHAS website. Two of the Champions developed alternative FA Update templates that you can use. The FA update could be an expanded progress note that documents in some detail the updated FA assessment information and

	how that links to the updated treatment/recovery plan. In addition, you could document on the recovery plan review that the FA was reviewed/updated to inform the recovery plan update.
# 14 and 15 <u>Documentation</u>	If any of the subcomponents of these items are missing in all charts reviewed, the rating will be a one "1" for the relevant fidelity scale items.
# 17 <u>Encounter Notes</u>	Encounter noted should follow the GIRP format(**G**oal, **I**ntervention, **R**esponse, **P**lan(what the next steps will be). Notes reviewed should show evidence that the "G" for goal should reference back to the IRP and not for the "goal for the day". If staff are documenting a lot of notes for a specific goal and it is not on the IRP they should be updating the IRP earlier than the 90 day requirement.
# 18 <u>Stages of Change</u>	Stage of change is assessed and interventions are appropriately matched. Client charts show evidence of stagewise services and staff can articulate appropriate matching strategies. See chart below:

Stages of Change	Stage of Tx	Interventions
Precontemplation Does not see Substance abuse or mental illness as a problem, is unwilling to change, or feels unable to change.	Engagement	* Develop a working-together relationship * Remain positive and optimistic * Don't worry about enabling * Use *Motivational Interviewing* to **Express Empathy** and **Establish Personal Goals** * Provide practical assistance * Reduce harmful consequences * Provide outreach if necessary *Listen for ambivalence about problem behavior * Reflect client statements of the downside of problem behavior * Learn how client experiences life now and how this is different from hopes and aspirations *Increase awareness of the problem* Express benefits of change * Don't push treatment *
Contemplation Has become aware that SA/mental illness is a problem and is ambivalent about change	Persuasion	*Client will think a lot and say a lot, but may not do a lot * Be aware that client is weighing the pros and cons of problem behavior, avoid the **Righting Reflex** by not offering advice or correcting misperceptions * Use *Motivational Interviewing* for **Developing Discrepancy** between problem behavior and client goals/values * Provide information about SA/mental illness and benefits of treatment * Use individual MI, Persuasion Groups, and Family interventions * Use *Motivational Interviewing* to **Support Self-efficacy,** to **Avoid Arguments,** and **Roll with the Resistance** * Assure client that ambivalence is normal * Use **Decisional Balance** worksheet *
Preparation Made the decision to change soon and is developing a growing commitment to change.	Persuasion	* Use *Motivational Interviewing* to **Support Self-efficacy** * Teach about alcohol, drugs, mental illness, activities that promote health and wellness * Improve social support * Refer to therapy, self-help groups * Offer skills training/CBT * Reach out and support families * Encourage commitment to change * Generate a plan and set-up action goals * Support small steps toward change to "test the waters" * Reinforce small successes and problem-solve ways to handle difficulties that arise *
Action Attempts change by implementing a plan. Problem behavior is decreased or stopped for 1 to 180 days.	Active Treatment	* Verbally reinforce efforts and celebrate action steps * Use *Motivational Interviewing* to **Support Self-Efficacy** * Link new behaviors with positive outcomes you see * Teach new skills such as drug-refusal skills, identifying and managing triggers and cravings, social skills, stress management * Expand support to self-help and substance-free social activities * Encourage lifestyle changes to support recovery and gain meaningful activity * Attend Active Treatment Group
Maintenance Committed to change, uses strategies and has not had problem behavior for 6 months	Relapse Prevention	*Develop a relapse prevention plan to deal with people, places, and things that trigger cravings * Attend Relapse Prevention groups * Expand meaningful activity * Develop new goals to enhance quality of life * Help maintain awareness that relapse can occur * Discourage over-confidence * Empathize with feelings about slips and reframe as opportunity to learn, be stronger, cope better * Teach CBT/Coping

# 19 <u>Skill-Building Interventions</u>	Reviewers will ask to review your skill-builder toolkit. Reviewers will be assessing if staff routinely use skills lists, skill-builder toolkits and curricula to guide skill-building interventions. Documentation shows evidenced of skill building language i.e. **Teaching, Coaching , Assisting, Prompting/prompted ,Cuing, Role-played, Modeled**, etc.
#20 <u>Mutual Support Groups</u>	Examples of assertive linkage to mutual support groups include: staff attend with client for 1st time, find sponsor/group, 12-step facilitation curriculum used, role play first meeting, debrief experiences . Mutual support is a purposeful gathering of individuals with a shared lived experience or condition intended to offer caring support, share practical coping strategies (e.g., AA, NA, Double Trouble in Recovery (DTR)). Charts reviewed should show evidence of this.
#21 <u>Wellness/ Recovery Groups</u>	These are usually more structured interactive experiences intended to promote health and well-being: Stress management, meditation, yoga, smoking cessation, exercise. WRAP, Recovery Pathways & Intentional Peer Support are recovery groups that offer a structured program led by individuals who have first undergone training. Charts reviewed should show evidence of this.
# 22 and 23 <u>Family Involvement</u>	•In both items "family" is broadly defined to include all natural support persons (e.g., significant other, friend). •The family group has been changed from a monthly requirement to a 12 times per year requirement (or at least 3 times per quarter; could be weekly). • For the item concerning family involvement: Team has regular contact with family members of at least 50% of clients. (This is based on the whole CSP/RP caseload.) Reviewers will ask your program for the list of CSP/RP clients that have some type of family involvement in CSP/RP services/recovery process and briefly what that involvement looks like (e.g., attending a tx plan meeting; be added to the recovery plan to assist with a certain goal/objective…to do a certain intervention; regular contact with the CSP/RP staff member etc.) This list is also an opportunity to meet the Family Group requirement by documenting which families attend the family group.